2003 Benefit Grids

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $1,500 Family: $3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$100 co-pay	$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay	$20 co-pay
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay	$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay	$125 co-pay
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$50 co-pay	$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	$20 co-pay	$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs **Retail**	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	$10 generic $15 brand $30 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary	$20 generic $30 brand $60 non-formulary
Dental		Not Covered	Not covered
Vision		Not Covered	Not covered
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-insurance	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay	$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $10 co-pay 50% co-insurance	 $20 co-pay 50% co-insurance
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	$250 co-pay

Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2003 Benefit Grids

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: $500 Family: $1,000	None	Single: $1,000 Family: $2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $2,500 Family: $5,000	Single: $1,500 Family: $3,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	$100 co-pay (per admission)	40% co-ins*	$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) - outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay (per visit)	40% co-ins*	$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay (per visit)	$50 co-pay plus 40% co-ins	$50 co-pay (per visit)	$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins	20% co-ins*	25% co-ins	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary		$20 generic $30 brand $60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness, or injury.	50% co-ins		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-ins	40% co-ins*	25% co-ins	50% co-ins*
	Home Health	20% co-ins Limit 60 visits per year.	40% co-ins*	25% co-ins Limit 40 visits per year.	50% co-ins*
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $10 co-pay 50% co-insurance	 40% co-ins* 50% co-insurance*	 $20 co-pay 50% co-insurance	 50% co-ins* 50% co-insurance*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	40% co-ins*	$250 co-pay	50% co-ins*

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Referrals and/or prior approval may be required for some services. Please contact your Carrier.

2003 Benefit Grids

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: $250 Family: $500	Single: $500 Family: $1,000	Single: $500 Family: $1,000	Single: $1,000 Family: $2,000
Maximum out-of-pocket for Covered Expenses (including deductible)	Co-payments for office visits, hospital emergency room visits, urgent care center visits services do not apply to the out-of-pocket limits. Co-payments and co-insurance for prescription drugs do not apply to the out-of-pocket limits.	Single: $1,250 Family: $2,500	Single: $2,500 Family: $5,000	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)- visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	$10 co-pay (per visit) $400 maximum benefit per year	40% co-ins*	$20 co-pay (per visit) $300 maximum benefit per year	50% co-ins*
	Diagnostic Testing (per visit)- laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay plus 20% co-ins	$50 co-pay plus 40% co-ins	$50 co-pay plus 25% co-ins	$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins	40% co-ins	25% co-ins	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance (per use)	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs Retail	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$20 generic $30 brand $60 non-formulary		$20 generic $30 brand $60 non-formulary	
Dental		Not Covered		Not covered	
Vision		Not Covered		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins* Limit 60 visits per year.	40% co-ins*	25% co-ins* Limit 40 visits per year.	50% co-ins*
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $10 co-pay 50% co-ins*	 40% co-ins* 50% co-ins*	 25% co-ins* 50% co-ins*	 50% co-ins* 50% co-ins*
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit	Covered same as Medicare benefit
	Physical Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Skilled Nursing Facility (per visit) – Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.
Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.
Prior approval may be required for some services. Please contact your Carrier.

2003 Benefit Grids

EPO Plan		
Annual Deductible		None
Maximum out-of-pocket for Covered Expenses	Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$1,500 co-pay (per admission)
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	$25 co-pay (per visit)
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$500 co-pay (per visit)
	Diagnostic Testing (per visit) – laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay; a separate diagnostic testing co-pay will not apply.	$25 co-pay (per visit)
	Preventive Testing* – Covered at Health Departments. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations* – All early childhood immunizations; flu, pneumonia, and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$75 co-pay (per visit)
	Urgent Care Center (not hospital emergency room) (per visit)	$50 co-pay (per visit)
	Ambulance (per use)	$75 co-pay (per visit)
Maternity Care	Prenatal, labor, delivery, postpartum care, and one ultrasound per pregnancy. More than one ultrasound per pregnancy is only covered with prior Plan approval.	$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs **Retail**	Co-pay applies to each 1-month (30-day) supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	$25 generic $35 brand $50 non-formulary
Mail Order	Co-pay applies to each 3-month (90-day) supply of maintenance drugs only. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$50 generic $70 brand $100 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 15 visits per year. No more than one visit per day.	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Hearing Aids (Under 18 years of age. One per ear every three years, $1,400 maximum per ear.)	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism Services-$500 maximum monthly benefit. For children 2 through 21 years of age • Rehabilitative and Therapeutic care • Respite Care	 $25 co-pay (per visit) 50% co-insurance
	Hospice – Certain limits apply. Must be precertified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Occupational Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Cardiac Rehabilitation Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Speech Therapy (per visit) – Limit 20 visits per year.	$30 co-pay (per visit)
	Skilled Nursing Facility (per admission) – Limit 20 days per year.	$1,500 co-pay

*Health Departments shall be given the right of first refusal. Note: Only services from network providers are covered.

Referrals and/or prior approval may be required for some services. Please contact your Carrier.